TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Marcos S. Rodriguez, D.C.

Respondent Name
City of San Antonio

MFDR Tracking Number
M4-15-2876-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 5, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "… the exam was performed as requested on the DWC-32, the services were documented in the Designated Doctor report, and were billed accordingly on the CMS-1500. Additionally, the payment we received does not meet the suggested allowance set by the Texas Medical Fee Guidelines."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The enclosed medical records and DWC 32 indicate the Designated Doctor Examination was to determine maximum medical improvement, impairment rating and return to work status. There was not a request to address extent of injury.

Therefore, no allowance is due for procedure code 99456W6RE."

Response Submitted by: Argus Services Corporation

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 11, 2014	Designated Doctor Examination (RTW)	$150.00	$150.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the guidelines for billing and reimbursing Designated Doctor Examinations.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12A – Workers Compensation jurisdictional fee schedule adjustment. *Reimbursement per Rule 134.203/134.204. Prior to March 1, 2008, Rule 134.202.
   - 18 – Duplicate claim/service

Issues

1. What are the disputed services?
2. What is the Maximum Allowable Reimbursement (MAR) for the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier states in its position statement that "there was not a request to address extent of injury … no allowance is due for procedure code 99456W6RE." Review of the Medical Fee Dispute Resolution Request (DWC060) finds that the following CPT Codes are listed: 99456 W5 WP, 99456 W5 WP, 99456 W6 RE, and 99456 W8 RE. However, the only code that lists an amount in dispute is CPT Code 99456 W8 RE for $150.00. Therefore, this will be the only code considered in this dispute.

   28 Texas Administrative Code §134.204 (i)(1) states, in relevant part, "Designated Doctors shall perform examinations in accordance with Labor Code §§…, 408.0041 …. and Division rules, and shall be billed and reimbursed as follows: … (E) **Ability of the employee to return to work** [emphasis added] shall be billed and reimbursed in accordance with subsection (k) of this section, with the use of the additional modifier 'W8'." Therefore, the service in dispute is an examination to determine the ability of the employee to return to work.

2. Per 28 Texas Administrative Code §134.204 (k), "The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier 'RE.' In either instance of whether MMI/IR is performed or not, the reimbursement shall be $500 in accordance with subsection (i) of this section and shall include Division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee." The submitted documentation indicates that the Designated Doctor performed an examination to determine the ability of the employee to return to work, in accordance with the Division order. Therefore, the correct MAR for this examination is $500.00.

3. The total MAR for the disputed service is $500.00. The insurance carrier paid $350.00. Therefore, an additional reimbursement of $150.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $150.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $150.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	June 30, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.